STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445013	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, CHATTANOOGA	2700 PARKWOOD AVE CHATTANOOGA, TN 37404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on testing and observations, it was determined the facility failed to maintain the exits. The findings included: 1. Testing of the delayed egress exit door next to room 225 on 1/27/14 at 10:23 AM revealed that it did not release after fifteen (15) seconds. The magnetic lock did release upon alarm activation. 2. Observation on 1/27/14 at 10:43 AM revealed the following delayed egress doors were not labled with the proper signage: Patient Dining Room, Back Patio door from Station 3, Stairway door by room 428, and Station 4 front hall stairwel. These findings were verified by the maintenance supervisor during the facility survey and acknowledged by the administrator during the exit conference on 1/27/14.	K 038	K 038 SS=D Corrective Action: 1. The delayed egress exit door next to room 225 has been repaired to release after fifteen(15) seconds of constant pressure. To be completed by: 2. The delayed egress doors located at the Patient Dining Room, Back Patio Door from Station 3, Stairway Door by room 428 and the Station 4 Front Hall stairwell will all be labeled with proper signage by: Identifying Other Patients / Areas: 1. All other delayed egress exit doors released appropriately. 2. All other delayed egress exit doors had proper signage. Measure & Changes to be taken: 1. None other than corrective action detailed above. Monitoring Performance: Administrator or designee will use a QA monitor that will be developed to check delayed egress exit doors for proper release after 15 seconds of pressure and that they have proper signage. The QA monitor will be monthly for 2 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After 2 months of monitoring, QA frequency may be reduced depending on results. To be completed by:	2/10/14 2/15/14 3/15/14
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADM 2/12/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 130	Continued From page 1 National Fire Protection Association 101 Life Safety Code 2000 Edition 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire Barriers. 8.2.3.2.4.2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1)The space between the penetrating item and the fire barrier shall meet one of the following conditions: a.It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b.It shall be protected by an approved device that is designed for the specific purpose. (2)Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a.It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b.It shall be protected by an approved device that is designed for the specific purpose. (3)Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a.The material shall be capable of maintaining the fire resistance of the fire barrier. b.The material shall be protected by an approved device that is designed for the specific purpose. (4)Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:	K 130	K 130 SS=D Corrective Action: 1. The penetration in the fire barrier wall identified between the new and old building above the fire doors at the end of first floor corridor at barrier from independent living will be sealed and repaired by: Identifying Other Patients / Areas: 1. No other areas with penetrations were identified during the survey observations. Measure & Changes to be taken: 1. None other than corrective action detailed above. Monitoring Performance: Administrator or designee will use a QA monitor that will be developed to check fire barrier walls for penetrations. The QA monitor will be monthly for 2 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After 2 months of monitoring, QA frequency may be reduced depending on results. To be completed by:	2/10/14 3/15/14

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K 130	Continued From page 2 a.It shall be made on either side of the fire barrier. b.It shall be made by an approved device that is designed for the specific purpose. Based on observations, it was determined the facility failed to maintain the fire barriers. The finding included: Observation on 1/27/14 at 11:35 AM revealed penetrations in the fire barriers in the following locations: Wall between new and old building above the fire doors and at the end of first floor corridor at barrier from independent living. This finding was verified by the maintenance supervisor during the facility survey and acknowledged by the administrator during the exit conference on 1/27/14.	K 130		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations and testing, it was determined the facility failed to maintain the electrical system. The findings included: 1. Observation on 1/27/14 at 10:10 AM revealed computers located in front of electrical panels in the vending area and housekeeping areas.	K 147	K 147 SS=D Corrective Action: 1. The computers located in front of electrical panels in vending & housekeeping areas will be relocated by: 2. The extension cords and power strips in use at computer desk in housekeeping area, at the refrigerator next to Nurse Station 1, the business office and station 4 storage area will be removed by: 3. Storage blocking electrical panels in the Station 1 mechanical room, Station 2 mechanical room, Station 4 storage area and the electrical room in the laundry area will be removed by: 4. The multiplug adapter in use in the Station 2 day room will be removed by: 5. Electrical outlets within six (6) feet of the sink in the station 4 med room will be equipped with ground fault circuit interrupters by: Identifying Other Patients / Areas: 1. No other areas were identified during the survey. (Continued on next page)	2/15/14 2/15/14 2/28/14 2/15/14 2/15/14

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K 147	Continued From page 3 2. Observation on 1/27/14 at 10:11 AM revealed an extension cord in use at computer desk in housekeeping area. 3. Observation on 1/27/14 at 10:16 AM revealed back to back power strips at the refrigerator next to nurse satin 1. 4. Observation on 1/27/14 at 10:20 AM revealed furniture storage, blocking electrical panels, in the Station 1 mechanical room. 5. Observation on 1/27/14 at 10:30 AM revealed a multiplug adapter without overcurrrent protection in use in the station 2 day room. 6. Observation on 1/27/14 at 10:34 AM revealed excess storage in the station 2 mechanical room, blocking the electrical panels. 7. Observation on 1/27/14 at 10:40 AM revealed a power strip plugged into an extension cord plugged into a power strip in the business office. 8. Observation on 1/27/14 at 10:51 AM revealed storage blocking the electrical panel in the electrical room in the laundry area. 9. Observation on 1/27/14 at 10:53 AM revealed storage blocking the electrical panels in the station 3 electrical room. 10. Observation on 1/27/14 at 11:20 AM revealed the station 4 med room had electrical outlets within six (6) feet of a sink and not equipped with ground fault circuit interrupters. 11. Observation on 1/27/14 at 11:23 AM revealed storage in front of electrical panels and back to	K 147	K 147 SS=D Continued Measure & Changes to be taken: 1. Maintenance Staff will be inserviced on the use of extension cords and power strips. To be completed by: Monitoring Performance: 1. Administrator or designee will use a QA monitor that will be developed to monitor the use of extension cords, access in front of electrical panels and excess storage in mechanical rooms. The QA monitor will be monthly for 2 months with results reported to the QA Committee consisting of Medical Director or Physician Designee, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After 2 months of monitoring, QA frequency may be reduced depending on results. To be completed by:	3/15/14 3/15/14

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K 147	Continued From page 4 back power strips in the station 4 storage area. These findings were verified by the maintenance supervisor during the facility survey and acknowledged by the administrator during the exit conference on 1/27/14.	K 147	(Page Intentionally Blank)	